



CITY OF CHICAGO BENEFITS MANAGEMENT OFFICE

333 S. State Street, Room 400
Chicago, Illinois 60604-3978

**Application for
Public Safety Employee Benefits under the Public Safety Employees Benefits Act,
820 ILCS 320/10**

As required by the Illinois Public Safety Employees Benefits Act, 820 ILCS 320/10 ("PSEBA"), the City of Chicago pays the premium of its basic group health insurance plan for certain police officers and firefighters, their spouses and dependent children. To be eligible for this PSEBA benefit, you must qualify under one of the following categories

1. You are a police officer catastrophically injured during response to fresh pursuit, or you are a police officer or firefighter catastrophically injured in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act.
2. You are the spouse of a police officer catastrophically injured or killed during response to fresh pursuit, or a police officer or firefighter catastrophically injured or killed in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act, and, if you are a surviving spouse, you have not remarried.
3. You are the child of a police officer catastrophically injured or killed during response to fresh pursuit, or a police officer or firefighter catastrophically injured or killed in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act, and:
 - you are under 18 years old, or
 - you are 18 -25 years old and you are a full-time or part-time student dependent for support, or
 - you are 18-25 and dependent for support.

The PSEBA benefit does not change other benefits for which injured police officers and firefighters and their families may be eligible under applicable collective bargaining agreements.

If you believe you are eligible for the PSEBA benefit, complete the attached PSEBA Application Form and the Authorization Form for the Use and Disclosure of Protected Health Information and return both forms to:

**City of Chicago Benefits Management Office
333 S. State Street, Room 400
Chicago, Illinois 60604-3978**

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PSEBA APPLICATION FORM

1. Applicant's Name: _____

2. Applicant's Social Security Number _____ - _____ - _____

3. Mailing Address

4. Telephone: (Home) _____ (Work) _____

5. Applicant's birth date _____

6. Name of Public Safety Employee _____

Birth date of Public Safety Employee _____

- ☐ Police Officer
☐ Firefighter
☐ Firefighter/paramedic

7. Applicant's relationship to the person named in #6.

- ☐ Self
☐ Currently married
☐ Surviving Spouse, not remarried
☐ Child under 18
☐ Child 18-25 dependent for support
☐ Child 18-25 and full-time or part-time student and dependent for support. Attach proof of your status as a student.

8. Date of Public Safety Employee's injury and/or death _____

9. Location of Public Safety Employee's injury and/or death

10. Description of how injury and/or death occurred (you may attach any official reports or other documentation of the circumstances of the injury and/or death)
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10. Have you made any other requests for PSEBA benefits?

☐ No

☐ Yes. Provide date, where application was made, and reason application was made. Attach copy of application, if available.

11. Has the Public Safety Officer applied for a line-of-duty-disability pension from the Chicago Firemans' Annuity and Benefit Fund or from the Chicago Policemen's Annuity and Benefit Fund?

☐ No

☐ Yes. Attach copy of application

Has the Chicago Firemans' Annuity and Benefit Fund or from the Chicago Policemen's Annuity and Benefit Fund granted the Public Safety Officer a line-of-duty disability pension?

☐ No, attach copy of denial, if any

☐ Yes, attach copy of determination letter

12. List any other health insurance plans under which you are covered. Include the name of the insurance company and benefit plan.

The undersigned, who has applied to the City of Chicago Benefits Management Office for the PSEBA benefit, states as follows:

1. I believe I may be eligible for benefits under the Public Safety Employee Benefits Act, 820 ILCS 320/10, and submit the above information in support of my application.
2. I understand that to determine eligibility for these benefits, the City of Chicago may need to review relevant employment and pension records for the injured or deceased Public Safety Officer. I hereby authorize the City of Chicago to review records from the Chicago Police Department and/or the Chicago Fire Department and/or the Fireman's Annuity and Benefit Fund of Chicago and/or Policemen's Annuity Benefit Fund of Chicago.
3. I understand that to determine eligibility for these benefits, the City of Chicago may need to review relevant medical records for myself and/or the injured or deceased Public Safety Officer. I have completed and signed the attached Authorization Form for the Use and Disclosure of Protected Health Information authorizing the City of Chicago to review these records.
4. I understand that while my application is being considered and at anytime I am receiving benefits under the Public Safety Employees Benefits Act I must obtain Medicare coverage when I become eligible through my own employment, a spouse's employment and/or an ex-spouse's employment.
5. I understand that I am obligated to inform the City of Chicago, Benefits Management Office, 333 S. State Street, Room 400, Chicago, IL 60604-3978 while my application is being considered and at any time I am receiving benefits under the Public Safety Employees Benefits Act if :
 - I remarry.
 - I am 18-25 and no longer dependent for support or I am no longer a full-time or part-time student.
 - I am eligible for other health insurance and/or I obtain other health insurance, including Medicare.
6. I understand that it is unlawful for a person to willfully and knowingly make or cause to be made, or to assist, conspire with, or urge another to make, or cause to be made, any false, fraudulent, or misleading oral or written statement to obtain health insurance coverage as provided by the Public Safety Employee Benefits Act 820 ILCS 320/10(a)(3). I understand that such actions constitute a Class A Misdemeanor and can serve as the basis for denial of benefits and/or forfeiture of any benefits paid. Further, I understand any omission of information related to this application could constitute a basis for denial.

Signature of Applicant

Date

Printed Name of Applicant

Printed Name of Personal Representative (if applicable)

Relationship to Applicant (if applicable)



City of Chicago Benefits Management Office
Authorization Form
For the Use and Disclosure of Protected Health Information

Name _____ City Employee Name _____
Social Security Number _____ City Employee Social Security Number _____
Date of Birth _____

By signing this Authorization Form, I understand that I am giving my authorization to the Benefits Management Office to use/or disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____

Street Address: _____

City, State, and zip code: _____

Telephone number: ____/____/____ Facsimile number: ____/____/____

I specifically authorize the use and disclosure of the following PHI:
(Please provide a detailed description of each purpose of the requested use or disclosure. Also include the particular data and period of time you are requesting.)

☐ Enrollment/Disenrollment Information. _____

☐ Other. _____

This authorization shall not expire unless revoked.

I may revoke this authorization at any time by notifying the City of Chicago in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed by the City of Chicago before the City received the written notice of revocation.

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary and I may refuse to sign this Authorization form.

I understand that the City of Chicago's Benefits Management Office may not condition payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the authorization is requested prior to enrollment and is sought for eligibility or enrollment determinations or for our underwriting or risk rating determination.

I understand that I have a right to inspect and copy the information for which I am authorizing disclosure.

I understand that I have the right to be provided with a copy of this signed authorization form.

Signature of patient/claimant/personal representative

Date

Printed name of patient

Printed name of personal representative (if applicable)

Relationship to patient (if applicable)



City of Chicago
Richard M. Daley, Mayor

CITY OF CHICAGO GROUP HEALTH PLANS NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The City of Chicago is the sponsor of seven self-funded medical plans, and self-funded dental and vision plans. As the sponsor of the self-funded plans, the City of Chicago is required to send you this Notice of Privacy Practices that describes how medical/dental/vision information about you may be used and disclosed and how you can get access to the information.

This Notice of Privacy Practices describes how the City of Chicago may use and disclose your protected health information (PHI) for payment, health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

What is Protected Health Information?

“Protected Health Information” is information about you, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health/dental/vision care to you; or (iii) the past, present, or future payment for the provision of health/dental/vision care to you.

The City is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. You may obtain a copy of the Notice of Privacy Practices by accessing the City of Chicago’s web site, www.cityofchicago.org/finance/BenefitsInfo, or by calling the City of Chicago Benefit Management Office’s Privacy Officer to request that a copy be mailed to you.

PLANS COVERED BY THIS NOTICE

The City of Chicago has delegated Plan Administration duties, including claim appeals, to the Benefits Management Office for its self-funded plans. In addition, the Benefits Management Office manages the enrollment and eligibility functions of the medical HMO’s, the dental HMO’s, as well as the self-funded health, vision and dental plans for employees and annuitants. We also provide customer service for all Benefit programs and staff a Continuation of Coverage Unit for employees on leave who wish to continue coverage, or others who lose eligibility due to age, termination, divorce or retirement and who wish to continue coverage in one or more programs by paying for the coverage.

Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these services, business associates will receive, create, maintain, use or disclose protected health information. We require these business associates to agree in writing to contract terms designed to safeguard your information. For example, we may disclose protected health information to business associates to provide utilization management, investigate subrogation, and to provide pharmacy benefit management services to the self-funded plans.

The City of Chicago contracts with Claim Administrators (Business Associates) for the City's self-funded programs *to process claims* for eligible City of Chicago employees, retirees and dependents. The Benefits Management Office does not store claim records, thus if you want information contained in claims records, you will need to contact the appropriate claims administrator. Please note: you will receive a HIPAA Notice of Privacy Practices, separate from this Notice, from any HMO in which you are enrolled.

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations

Federal law allows a group health plan to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. §164.501 (this provision is part of the HIPAA Privacy Regulations). We have not listed all the activities included within these definitions. We have instead given examples of the uses and disclosures that we, as a group health plan, may make under each section, as listed below:

The Plan will also disclose PHI to the Plan Sponsor, the City of Chicago, for purposes related to payment and health care operations. The Plan Sponsor has amended its plans' documents to protect your PHI as required by federal law.

- ☐ **Payment.** Payment refers to the activities involved in the collection of premiums and the payment of claims under the plan for the health/dental/vision care services you receive. The City has contracted with Third Party administrators to perform many of the activities considered to be payment activities. Examples of uses and disclosures under this section include (i) the sharing of PHI with other insurers to determine coordination of benefits or to pursue subrogation claims; (ii) providing PHI in the billing, collection and payment of premiums and fees to plan vendors such as PPO Networks, Prescription Benefit Management Companies, Vision and Dental Plans, and reinsurance carriers; and (iii) sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.
- ☐ **Health Care Operations.** Health care operations refers to the basic business functions necessary to operate a group health plan. Examples of uses and disclosures under this section include (i) responding to a customer service inquiry or an appeal of a denial of coverage from you; (ii) conducting quality assessment studies to evaluate the plans' performance or the performance of a particular network or vendor; (iii) the use of PHI in determining the cost impact of benefit design changes; (iv) the disclosure of PHI to the underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the plan; (v) disclosure of PHI to other departments within the City of Chicago that provide legal, actuarial and auditing services to the plan; and (vi) use of PHI in general data analysis used in the long term management and planning for the plan and the City.

We may disclose your medical information to another entity that has a relationship with you and is subject to the Federal Privacy Rules, for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

Other Uses and Disclosures Allowed Without Authorization

Federal law also allows a group health plan to use and disclose PHI, without your consent or authorization, in the following ways:

- ☐ To you, as the covered individual.
- ☐ To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of a child, or the surviving family members or representative of the estate of a deceased individual.
- ☐ To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.

- ☐ To a business associate as part of a contracted agreement to perform services for the group health plan.
- ☐ To a health oversight agency, such as the Department of Labor, the Internal Revenue Service and the Insurance Commissioner's Office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses.
- ☐ In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- ☐ As required for law enforcement purposes. For example, to notify authorities of a criminal act.
- ☐ As required to comply with Workers' Compensation or other similar programs established by law.
- ☐ To the Plan Sponsor, as necessary to carry out administrative functions of the plan such as evaluating renewal quotes for reinsurance of the plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the plan. Please see your summary plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.
- ☐ For underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.
- ☐ For distribution of health related benefits and services. The Plan may use or disclose your health information to provide to you information on health related benefits and services that may be of interest to you.
- ☐ For treatment alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

The examples of permitted uses and disclosures listed above are not provided as an all inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures

You have the right to request that the plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Officer listed in this Notice at the Benefits Management Office, 333 South State Street, Room 400, Chicago, IL. 60604-3978 and must state the specific restriction requested and to whom the restriction would apply.

The plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Officer listed in this Notice at the Benefits Management Office, 333 South State Street, Room 400, Chicago, IL. 60604-3978.

Right to Access to Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the plan maintains the PHI. A designated record set contains claim information, premium and billing records and any other records the plan has created in making claim and coverage decisions relating to you. Federal law prohibits you from having access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Officer listed in this Notice. **Requests for claim information contained in a record set should be directed to one of the third party claim administrators.**

Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as the plan maintains the PHI. The plan may deny your request for amendment if it determines that the PHI was not created by the plan, is not part of the designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is denied, you have the right to have a statement of disagreement included with the PHI and the plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Officer listed in this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the plan after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Officer listed in this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with the plan or the Secretary of the U.S. Department of Health and Human Services. Complaints should be filed in writing with the Privacy Officer listed in this Notice. The plan will not retaliate against you for filing a complaint.

PRIVACY OFFICER

You may contact the Privacy Officer for the plan at (312) 747-8660.

EFFECTIVE DATE OF NOTICE

The notice was published and becomes effective on April 14, 2003.